ATTACHMENT 1:

2017~~6~~ Reporting Form for Quality Metrics
(Measurement Period: Calendar Year 2016~~5~~)

THIS IS A FILLABLE FORM, PLEASE COMPLETE ELECTRONICALLY

PCMH Organization name: _____
(PCMH Name)

PCMH Official providing report: _____, _____
(Name) (Title)

_____, _____
(Phone) (E-mail)

Date report submitted: _ _ / _ _ / _ _ _ _
(Mo/Da/Year)

If the CSI has questions pertaining to the data provided in this report, the data contact person for your organization is: _____, _____,
(Name) (Title)

_____, _____
(Phone) (E-mail)

DATA FROM CALENDAR YEAR 2016~~5~~
Two options exist for reporting in 2017~~6~~. Which one of these options are you using?

_____ **Option 1:** A **patient-level data report** with the data elements required from the table in Attachment 3 for each measure, for each patient, provided in a separate electronic file. Also complete the form below.

OR

_____ **Option 2:** An **attested aggregate data report**, using the form below, with data confirmed by the staff in the organization.

You can use the following to report MT PCMH measures for Option 2:

- Meaningful Use Clinical Quality Measure (CQM) reports out of your 2014 certified E.H.R for the full reporting period to provide the numerators and denominators for Option 2 for the measures with the corresponding CMS/NQF numbers.

Which report did you use to create the data you are submitting?

_____ Standard Clinical Quality Measure (CQM) report out of your 2014 certified EHR
_____ Standard Uniform Data System (UDS) report out of your 2014 certified EHR
_____ Customized report out of your 2014 certified EHR
_____ Combination of customized reports out of your 2014 certified EHR and chart abstraction
_____ Other - Please define: _____

_____ Unsure (if you select this option, please call Cathy Wright at 406-444-3415)

Please Note:

- In ~~both 2016 and~~ 2017, a PCMH must use the same metrics as reported in 2015 and 2016. However, a PCMH may report on additional metrics at any time.
- In 2017, for the 2016 measurement period, ~~reporting requirements will change from three out of~~ PCMHs must report on ~~five to~~ four out of five metrics.
- ~~Also in 2017, for the 2016 measurement period~~**~~, patient-level data will be required.~~**

The form below is required for BOTH Options 1 and 2. Please fill in the numerator and denominator for four of the metrics.

Metric 1: Controlling High Blood Pressure
MEASURE NUMBERS: CMS 165v~~43~~/NQF 0018~~/PQRS 236~~

1. _____(#): denominator - number of patients 18 through 85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period of calendar year 2016.
2. _____ (#): numerator - number of patients in the denominator whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.

Metric 2: Tobacco Use: Screening and Cessation Intervention
MEASURE NUMBERS: CMS 138v~~43~~/NQF 0028~~/PQRS 226~~

1. _____ (#): denominator - All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period of calendar year 2016.~~total number of patients aged 18 years and older who had a visit during the measurement period of calendar year 2015~~.
2. _____ (#): numerator - Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user~~total number of patients in the denominator population who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user.~~

Metric 3: Diabetes: Hemoglobin A1c Poor Control
MEASURE NUMBERS: CMS 122v4~~V3~~/NQF 0059~~/PQRS 001~~

1. _____ (#): denominator – number of patients 18 through 75 years of age who have the diagnosis of diabetes mellitus (type 1 or type 2), and had a visit during the measurement period of calendar year 2016~~5~~.
2. _____(#): numerator - number of patients in the denominator population whose most recent HbA1c level (performed during the measurement period of calendar year 2015) is > 9.0%

Metric 4: Rate of Fully-immunized 23-year-old children
MEASURE NUMBERS: ~~N/A (HRSA Quality of Care Measure)~~CMS117v4/NQF 0038

PLEASE NOTE: Patients with a medical contraindication to any immunization should be excluded from (1). Patients who refused an immunization should be included in (1).

1. _____ (#): denominator - Children who turn 2 years of age during the measurement period and who have a visit during the measurement period of calendar year 2016~~number of children in the PCMH patient population aged 36 months by January 1, 2016, with a visit during the measurement period~~.
2. Numerators – Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday~~enter below the number of children meeting criteria in (1) who received the indicated amount of doses of each immunization below.~~

NUMERATORS

	4 DTAP
	3 polio
	1 MMR
	3 Hib
	3 HepB
	1 Var
	4 PCV
	1 HepA
	2 or 3 RV
	2 Flu

3. _____number of children meeting criteria '1' who received all of the following: ≥4 doses of DTaP, ≥3 doses of HepB, ≥3 doses of Hib, ≥3 doses of IPV, ≥1 dose of MMR, ≥4 doses of PCV, ~~and~~ ≥1 dose of VAR, 1 dose of HepA, 2 or 3 of RV, and 2 Flu~~.~~

Metric 5: Screening for Clinical Depression and Follow-up Plan
MEASURE NUMBERS: CMS 2v54/NQF 0418~~/PQRS 134~~

~~**PLEASE NOTE: Reporting on depression screening in 2016 is optional, but highly encouraged. Reporting requirements in 2017 will change to four out of five metrics. CSI appreciates clinics willing to optionally submit depression screening data now, in preparation for next year.**~~

1. _____ (#): denominator - all patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period, of calendar year 2016.~~all patients aged 12 years and older in the entire clinic population with a visit during the measurement period of calendar year 2015~~.
2. _____ (#): numerator - patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen.